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Why did I receive a Family PACT Provider Profile?
All Family PACT providers who served more than 50 clients in any of the six-month periods are identified in the report are receiving profiles. If the number of clients served was less than 50 in any of the six-month periods, that portion of the profile will be marked "NA" meaning these data are not available. The number of clients served is based on paid claims data. Denied claims that were never paid are not included.

Who else sees my profile?
Provider Profiles are confidential and are issued only to the medical director/physician owner of the practice identified within the report. Profiles are not released to other providers, to clients, or to the public. It is your choice to share your profiles with others; however, OFP will not do so on your behalf.

Does Office of Family Planning (OFP) have any expectations or benchmarks for the indicators?
The only indicator that has an associated benchmark is "Chlamydia Screening for Women under Age 26." Please look at the profile carefully as your practice should strive to achieve the 95th percentile for this indicator. This CDC guideline was incorporated into the Family PACT Standards in 2003, and OFP's expectation is that it be widely practiced. For information on the Web, go to the CDC Web site at http://www.cdc.gov/STD/LabGuidelines/rr5115.pdf and http://www.cdc.gov/std/chlamydia/STDFact-Chlamydia.htm#diagnosed, as well as the U.S. Preventive Services Task Force at http://www.ahrq.gov/clinic/uspstf/uspschlm.htm.

Will I be audited by the California Department of Health Services (CDHS) as a result of the profiles?
Your Provider Profiles report is intended to be informational. Only when practice patterns reflect *consistently significant* outlier practices in relation to peer groups will referrals for potential additional review be made to the Audits and Investigations Branch of the CDHS. It is unlikely that aberrant profiles alone would generate an audit. However, they may be a component of the information that CDHS uses in determining who is audited.

If I make a change in my practice, when will it show in my profiles?
Should you elect to make changes in your practice as a result of these data, the impact will appear in future profiles that reflect the six-month time period in which you make the changes. For example, if you made a change in October 2005, data will be included in the July 2006 profile. However, a complete six-month period of data will be reflected in the January 2007 profile. The lag time is due to the six-month allowance for claims submission and time for data transfers and analyses. It is OFP's intention to offer profiles on a semi-annual basis, with the profiles becoming an integral part of the program's ongoing provider support activities.

The profiles show my data in relation to my professional peers. How do you decide who my peers are?
Two peer groups have been defined: "Private Sector Providers" and "Public Sector Providers." Your designation as a public or private sector provider is determined by the "provider type" that your practice was assigned when you enrolled as a Medi-Cal provider. In general, "public sector" providers are licensed as governmental, non-profit agencies and community clinics, and "private sector" providers are the remainder of the network. For additional information on peer groups, please see *Interpretation of Provider Profiles Reports*.

What do I do with this information?
OFP hopes that this information will be useful to you in reviewing your utilization management and quality of care practices for Family PACT clients. Options for using this information may include but are not limited to:

- Developing an internal quality improvement plan; additional staff and biller training
- Assessing communications among front-office staff, clinicians, and billers
- Instituting chart prompt reminders
- Improving client eligibility screening and intake practices
- Improving oversight of services ordered

Immediate assistance for client enrollment and billing is available by contacting the Electronic Data Systems (EDS) Telephone Service Center at (800) 541-5555, option 15. Upon request, a field representative will contact you directly to assist you. Future Family PACT educational events, such as audio-conferences, will include professional quality improvement topics.

I have two offices and received a profile for one but not the other. Why is that?
Data are linked to specific provider numbers under which providers and clients are enrolled and for which claims are paid. It is likely that most of your clinical activity is conducted at one site or the second site did not meet the threshold number of 50 Family PACT clients served in any of the reporting periods. If you believe you should have received a profile, please communicate with OFP staff by using either the Provider Response Form included in the packet, by calling (916) 650-0414, or by sending an email to fampact@dhs.ca.gov.

How do I update the address on my profile?
To update OFP's contact mailing list for Provider Profiles for any discrepancies in the name listed for physician owner/medical director or the mailing address (including suite number and zip code), please contact OFP using any one of the following three ways:

1. The *Provider Response Form* included in the envelope which you may:
   - Fax both sides to OFP at (916) 650-0454, or
   - Mail to: ATTN: Provider Profiles
     Department of Health Services
     Maternal Child Adolescent Health/Office of Family Planning
     P.O. Box 997413, MS 8400
     Sacramento, CA 95899-7413
2. Email OFP at fampact@dhs.ca.gov
3. Telephone OFP at (916) 650-0414

The contact mailing list OFP is using for the Family PACT Provider Profiles is not identical to the *official* Medi-Cal Provider Master File (PMF). **It is very important that you contact Medi-Cal for official address changes**. Instructions and forms to report changes and updates are found on the Medi-Cal web site at www.medi-cal.ca.gov. On the main menu, click on *Provider Enrollment*. It is the provider's responsibility to update information contained in the PMF, and OFP is unable to make these official changes on your behalf.

There is something unique about my practice that I think OFP should know about. How do I communicate with OFP?
If there is something unique about your practice or your client population that may influence interpretation of a measure that you would like to tell OFP about, you may do so using the *Provider Response Form* in your packet. We will make note of your comments so that it won't be necessary to continue to advise OFP.

I am the medical director of a group practice with offices in several locations each with a different provider number. How can I see a picture of my entire practice?
We anticipate offering an aggregate profile in addition to one for each of your sites' provider numbers. You may request an aggregate profile by using the Provider Response Form or by sending an email to fampact@dhs.ca.gov. Include with your request all provider numbers affiliated with your group and identify which site should receive the aggregate profile. At a future release of Provider Profiles, you will receive one aggregate profile for your group along with the individual site's profiles.

The number of clients or the number of encounters (the "n") used in each indicator is not the same from one graph to the next. In other words, there does not seem to be a common denominator between measures. Why is that?

While drawn from the same large data pool, the subsets of clients included in each measure are different among the eight indicators. Consequently, the denominators for each indicator will differ since the size of the subsets will vary depending upon the rules of the analysis. The rationale for inclusion in these denominators is as follows:

- The Average Family PACT Reimbursement per Client indicator is comprised of clients that a provider has served over a twelve-month period (the six-month period of interest plus the previous six months). To assure that a laboratory or pharmacy claim for a given client can be linked to a specific clinical practice, clients that were served by more than one Family PACT clinician provider during this twelve-month period are excluded.
- In contrast, the Family PACT Encounters per Client indicator only included clients that had one or more paid claim(s) during the twelve-month period for any of the following CPT codes: 99201-99204, 99211-99214, Z9750-Z9754, Z9760, and Z9761. Note that clients who were seen during the twelve-month period without one of these codes are not included in this measure. Also, since this measure is only concerned with the encounters a client has with a given provider, it is not necessary to exclude clients who were served by multiple providers.
- The Pregnancy Tests per 100 Family PACT Encounters includes all encounters (CPT codes as described above) with *female* clients during the six-month period of interest.
- The Social Security Number Reporting among Family PACT Clients includes only clients certified from whom we can reasonably expect to obtain a Social Security Number, U.S. born adults.
- The denominator for the Percent of Family PACT E&M Visits Coded 99214 includes only claims for CPT codes 99211 through 99214 for dates of service during the six-month period of interest.
- Likewise, the denominator for Percent of Family PACT E&C Visits Coded Z9754 includes only claims for HCPCS codes Z9750 through Z9754 for dates of service during the six-month period of interest.
- The Chlamydia Screening Rate for Family PACT Women Under 26 includes only women under 26 who were served during a six-month period.
- The Chlamydia Screening Rate for Family PACT Women Ages 26 or Over includes only women aged 26 and older who were served during a six-month period.

What are possible reasons for why my chlamydia testing performance is lower than expected?

Reasons for low performance can be due to clinical practice patterns such as not being familiar with the Family PACT/CDC screening recommendations, lack of chart reminders for clinicians to screen young women annually, not screening young women who are perceived to be at “low risk,” and not conducting a risk assessment to determine if a client should be screened. Other reasons could be associated with the method used to calculate performance, which depends on linking clients served by a specific provider with a laboratory claim for a chlamydia test; these may include laboratory billing problems, clients seen by multiple providers or clients whose chlamydia tests are paid for by another payer such as Medi-Cal or commercial insurance.

How do I decide which clients older than 25 years of age should receive a chlamydia test?
Evidence-based guidelines support routine chlamydia screening in women age 25 years and younger; however, chlamydia screening in women over age 25 should be very selective. A sexually active woman over age 25 should be tested for chlamydia under the following circumstances: 1) she has evidence of infection on clinical exam (e.g., cervicitis, signs of PID); 2) she reports sexual contact with a male partner with chlamydia, gonorrhea, or urethritis; 3) she is diagnosed with a new sexually transmitted infection (STI); 4) she reports risk factors (e.g., more than one male sex partner in the previous 12 months, a male sex partner who has other partners), or 5) she had chlamydia or gonorrhea in the previous two years.

What's the problem with routine chlamydia screening in women older than 25 years of age?
Screening that is unnecessary is not without risk. In the case of chlamydia screening, the primary risks include false positives, unnecessary treatment, as well as the unjustified financial burden to the Family PACT program. Because the prevalence of infection is low, the positive predictive value of the screening test is compromised resulting in an increased proportion of false positive test results. These false positives result in unnecessary treatment as well as psychosocial stresses that often accompany the diagnosis of an STI.

Why are some measures annualized and others are not?
The Family PACT Reimbursement per Client and the Family PACT Encounters per Client indicators are both annualized because the services delivered to a given client are not likely the same from one six-month period to the next (e.g., multiple encounters and lab tests in the first six months and perhaps only oral contraceptives in the second). An annualized measure is more reflective of services delivered than a snapshot of a six-month period.

In contrast the Pregnancy Tests per 100 Family PACT Encounters, the Social Security Number Reporting Among Family PACT Clients, the Percent of Family PACT E&M Visits Coded 99214, the Percent of Family PACT Visits Coded Z9754, the Chlamydia Screening Rate for Family PACT Women Under 26, the Chlamydia Screening Rate for Family PACT Women 26 or Over are all proportions of a service delivered or of clients certified. There is no reason to expect that these proportions will be inherently different over a six-month period versus a twelve-month period.

My staff seems to do a good job of collecting Social Security Numbers for U.S. born adults, so why doesn't my profile reflect that?
Site visits conducted by OFP and Centers for Medicare and Medicaid Services (CMS) in fall 2005 showed several instances in which intake staff were collecting Social Security Numbers (SSN) but failed to enter them into the HAP card activation and update system (e.g., POS device, Internet, or AEVS). Additionally, OFP found that the SSN may be recorded elsewhere in the client's chart but not included on the CEC form or entered in the certification system. An individual's SSN is considered Personal Health Information

and thus protected by HIPAA regulations and practices and clients should be reassured that their personal information is kept confidential. The collection of SSN is reflected in your profiles only when the SSNs are entered into the enrollment certification system. For additional information about this profile indicator, see the *Interpretation of Provider Profiles Reports* document.

Why does my profile show "NA" for some of the indicators?
Several criteria have been identified that allow for those providers to receive *Provider Profiles*. These criteria are:

- Profiles reflect only the activity of the provider(s) and the site associated with the Provider Number printed on the report.
- Clinician providers will have served, and successfully billed for, more than 50 Family PACT clients in the six-month reference period.
- Where the indicator represents female clients only, the clinician provider will have served more than 50 female clients in the six-month reference period.
- Where "per client" data are reported, the provider is the only identifiable clinician serving the client in the referenced timeframe.

Where your data are insufficient for a given indicator during an identified six-month period, you will see "NA" (not available) meaning that the data for the measure is not available for the time period.

How do I give feedback to OFP?
Included in the packet of materials you received is a *Provider Response Form*. We encourage the use of this form to update the contact information of the office associated with this provider number. Additionally, if you have affiliated practices for which you would like to receive an aggregate profile in future reports, you may use this form to list the additional sites. Finally, this form may be used to offer your feedback to OFP about the profile project. Your comments are welcome so that we may improve the project.

The *Provider Response Form* may be faxed (both sides of the form, please) to OFP at (916) 650-0454 or mailed to:

ATTN: PROVIDER PROFILES
California Department of Health Services
Maternal Child Adolescent Health/Office of Family Planning
P.O. Box 997413, MS 8400
Sacramento, CA 95899-7413

My practice is not doing a good job with Family PACT billing. How do we get billing assistance to improve claims payment and therefore my profiles?
The primary source for billing assistance is Electronic Data Systems (EDS), the fiscal intermediary for Medi-Cal, Family PACT and several other programs such as Breast and Cervical Cancer Treatment Program (BCCTP), Child Health and Disability Prevention Program (CHDP), and Cancer Detection Programs: Every Woman Counts. There are several ways to receive billing assistance:

- Call toll-free to the Telephone Service Center at (800) 541-5555. Listen for the menu prompt for "Health Access Programs: Family PACT."
- Medi-Cal Training Seminars, often with a session dedicated to Family PACT, publicized in the monthly *Medi-Cal Update* bulletin and through the Telephone Service Center at (800) 541-5555.
- Individualized contact with your EDS regional field representative arranged by calling the Telephone Service Center at (800) 541-5555. Regional field representatives can come directly to your site when necessary.

New staff members are welcome to attend Family PACT Orientation and Update Sessions held frequently throughout the State. While this is not a billing session, important information is presented on client enrollment, program standards and provider responsibilities. Attendees receive an introduction to Family PACT's Primary Diagnosis Codes (S-Codes), contraceptive method-specific services, as well as Education and Counseling office visits unique to Family PACT.

There is no charge to attend this all-day session, and the current schedule and reservation instructions are posted on the Family PACT web site at www.familypact.org and in the monthly *Medi-Cal Update* bulletin. Note: Staff members attending for an update will be furnished proof of participation but will not be issued the *Certificate of Attendance* used for provider application and enrollment.